



## Health Information Release Form

The Health Plan is able to release information regarding your account if this form is on file.

This release will allow another person to access your information. (This includes health information, which is any information that relates to your past, present, or future physical or mental health or medical condition). For example, a Subscriber can ask his/her spouse to check the status of a claim (this may include obtaining detailed claim and health information), change policy information (such as the address and telephone number), obtain Primary Care Physician (PCP) information, or change a PCP. If you would like to grant such permission to another person, please fill out, sign, and return this form to the address listed below or fax the form to 301-360-8915.

MAMSI Health Plans  
Customer Support Group  
P.O. Box 933  
Frederick, MD 21705

If you are a Subscriber or a Member and you wish to grant permission to another person with respect to your account information, please complete the following information:

MAMSI Health Plans has my permission to release any and all information to:

Representative Name: \_\_\_\_\_ Date of Birth (required): \_\_\_\_\_

He/she is being given the following access (please check one):

\_\_\_\_\_ complete authority (may obtain and make changes to any and all information)  
\_\_\_\_\_ inquiry only (may obtain any and all information but may not make changes)  
\_\_\_\_\_ PCP updates only  
\_\_\_\_\_ other limited access (please specify): \_\_\_\_\_

to the account listed below:

Member Number\*: \_\_\_\_\_

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

\*Subscribers should list the member number for each person for whose information they wish their representative to have access. Adult dependents must complete a separate Health Information Release Form in order for another individual to have access to their health information.

Please provide us with your telephone numbers so we may contact you with any questions regarding this information:

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

To revoke the access granted by this form, submit your request in writing to MAMSI Health Plans, Customer Support Department, P.O. Box 933, Frederick, MD 21705, or via fax to 301-360-8915. Please include your name, health plan identification number, and the name of your representative in your correspondence.